Provision	Kennedy – McCain - Edwards Bill (S.1052) Ganske – Dingell Bill (H.R. 526)	Fletcher-Peterson-Johnson (H.R.2315)
Latest Provisions	S. 1052 Senate passed June 29, 2001. The vote was 59Yea and 36 Nay	
Applicability & Scope	Applicable to all group plans and insurers, self-insured state and local plans, and all federal plans. Applies to about 231 million Americans.	Applicable to all group plans and insurers, including self-insured state and local plans, but not fee-for-service plans and federal government plans. Provides that conflicting state and federal standards do not apply simultaneously. Applies to between 170 million and 181 million Americans.
CBO Cost Estimate	4.2% increase in private health premiums. (Based on scored S.852) Could be higher with some of the amendments passed	Not scored yet, likely >3%
Pre-emption of State law	State laws preempted, unless "substantial compliance to" the federal law based on evaluation of Secretary. Claims, information, and appeals use the same standards.	Similar to Kennedy/McCain/Edwards
Effective Date	Plan years beginning on or after October 1, 2002.	If enacted in 2001, the later of January 1, 2003 or 18 months after Secretaries of HHS and Labor issue regulations.
Emergency Care	If plan or insurer offers emergency or ambulance coverage, it must, pursuant to a "prudent layperson" standard, provide coverage without prior authorization and regardless of provider participation in plan network. Beneficiary is not liable for additional costs if provider is not part of network.	Similar
Post stabilization following emergency care	Requires plan offering post-stabilization coverage, until it arranges for transfer or discharge, to provide such coverage if: (1) the plan fails to respond to a request for coverage within one hour of being contacted, or (2) the plan could not be contacted. Requires plan and issuers to adhere to guidelines developed by HHS for Medicare+Choice plans.	Similar.
Provider Choice (Point-of-Service)	Plan or issuer must offer participants, at enrollment or during open season, coverage through non-network providers (point-of-service) unless such option is already made available to the group. No small employer exemption. Plan may charge additional premiums and cost sharing.	Similar, except that groups of 25 and under are exempted from the provision
OB-GYN	Requires plans covering OB/GYN care and requiring designation of a primary care provider to make available direct access to such care by a participating health care professional specializing in OB/GYN without authorization by plan or primary care provider.	Similar

Provisions	Kennedy-McCain-Edwards	Fletcher-Peterson-Johnson
Pediatric Care	Pediatrician may be designated a child's primary care provider if in the plan network	Same.
Choice of Provider	Must allow beneficiary to choose any participating primary care physician as primary care provider, and on referral to receive care from any other participating provider who is available to accept beneficiary.	No provision.
Access to Specialists	Requires plan to provide timely access to participating specialists for care covered by plan. Referral may be required. If participating specialist is not available, a non-participating specialist must be allowed at no additional cost to beneficiary. Beneficiary with an ongoing special condition must be permitted to see a specialist with the authority to refer and coordinate care.	Similar to Kennedy/McCain/Edwards
Provider Discrimination	Plan may not discriminate against providers acting within the scope of their license or certification.	Similar
Hospital Stay Limit for Breast Cancer	Plan may not limit the number of inpatient days covered following a mastectomy, lumpectomy, or lymph node dissection for treatment of breast cancer. The "stay" decision is that of the attending physician in consultation with the patient. Plan must cover second opinion for all cancers.	No provision
Prescription Drugs	Plans using a formulary test must: ▪ Use physicians and pharmacists in the development of formulary. ▪ Disclose the formulary to the providers. ▪ Provide, at no additional cost, formulary exceptions when medically necessary.	Similar to Kennedy/McCain/Edwards, but does not prohibit cost-sharing for non-formulary drugs.
Continuity of Care	If a participating provider and/or treatment is terminated, the plan must notify patients in a timely manner and provide an opportunity for patients to request transitional care. Transition care must be provided as follows: ▪ Serious, complex conditions – 90 days. ▪ Institutional, inpatient care – earlier of 90 days or discharge. ▪ Scheduled surgery plus up to 90 days of post-surgical care. ▪ Pregnancy – through post partum. ▪ Terminal illness – life of the participant.	Similar to Kennedy/McCain/Edwards
Gag Rule	Prohibits plans from prohibiting or otherwise restricting communications between health care professionals and their patients on their medical status and treatment as long as the professionals are acting within the scope of practice.	Similar
Clinical Trials	Requires coverage of all clinical trails that are approved and funded by NIH, FDA, VA, or	Similar to Kennedy/McCain/Edwards, but payments must be at agreed upon rates.

Provisions	Kennedy-McCain-Edwards	Fletcher-Peterson-Johnson
	DOD. The plan must pay for routine patient costs, excluding the cost of tests or measurements conducted primarily for the clinical test. Uses Medicare rules. Plan may not discriminate against individuals on the basis of their participation in such trials.	
Financial Incentives	Requires plans to adhere to Medicare/Medicaid physician incentive requirements	Require IOM to study the impact of provider incentives on the quality of patient care and the ability of physicians to provide medically necessary and appropriate care.
Whistle Blower	Prohibits plans from retaliation against physicians or beneficiaries based on use of grievance procedures or involvement in regulatory action against plan.	No provision
Mandatory Plan Information	Requires plan to provide participants a list of information upon initial enrollment and annually in conjunction with election periods or at the beginning of coverage year. Plan must notify beneficiary of any change, regardless of how minor, 30 days prior to the change. No internet disclosure is allowed.	Similar to Kennedy/McCain/Edwards
Requested Information	Upon request, plan must provide participant with information on providers, drug formulary limitations, utilization review process, and other information.	Similar
Enforcement	No provision	Secretary of HHS may assess civil penalties up to $100 per day of violation. Penalty indexed to medical inflation.
Utilization Review	Utilization review programs must comply with written polices and be administered by health care professionals. Retrospective decisions must be consistent with pre-authorization decisions and limits are placed on frequency of reviews.	No provision
Initial Review Information	Plan must receive all necessary information within 5 days after request for information.	Plan must receive all necessary information within 5 days after request for information.
Initial Review Pre-Authorization	Standard Review: In accordance with medical exigencies and ASAP within 14 days of receipt of information, but no longer than 28 days from receipt of claim. Expedited Review: In accordance with medical exigencies, but no later than 72 hours after request. Concurrent Review: As soon as possible.	Standard Review: In accordance with medical exigencies and ASAP within 14 days of receipt of information, but no longer than 21 days from receipt of claim. Expedited Review: 72 hours after receipt of request. Concurrent Review: Within 24 hours of receipt of claim.
Initial Review Retrospective timeline	According to medical exigencies and ASAP within 30 days of receipt of all information and no longer than 60 days from receipt of claim.	Within 30 days of receipt of all information, but no longer than 60 days from receipt of claim.
Initial Review Notice of Denial	Must notify beneficiary and treating provider in accordance with medical exigencies and ASAP within 2 days after the determination. Failure to meet determination timelines is considered a denial.	Must notify participant and treating provider no later than 2 days after the determination. Failure to meet determination timelines is considered a denial.

Provisions	Kennedy-McCain-Edwards	Fletcher-Peterson-Johnson
Internal Appeal Request deadline	Beneficiary has 180 days from date of notice of denial to appeal decision.	Beneficiary has 90 days from date of denial to appeal decision.
Internal Appeal Timeline	Same as for initial review of pre-authorization.	Same as for initial review of pre-authorization.
External Appeal Deadline for request.	180 days after receipt of notice of claim denial or of plan's decision to waive appeal. Plan may request $25 fee (can be waived for indigence or if decision is overturned).	90 days after receipt of notice of claim denial or of plan's decision to waive appeal. . Plan may request $50 (can be waived for indigence or if decision is overturned)
Threshold	None	Provides that the external appeals process does not apply if the claim involved is for less than $100. The latter exclusion does not apply if physician has asserted in writing that there is a significant risk of placing the life, health, or development of the beneficiary in jeopardy if the denial of the claim for benefits is sustained or if the plan or issuer involved waives the internal appeals process.
External Appeal Information	Plan must submit necessary information within 5 days after request for information, or sooner if necessary for expedited reviews.	Same as Kennedy/McCain/Edwards
External Appeal Initial Screening	External review entity determines that request is eligible for review.	Same
External Appeal Standard of review	External review entity must make "new independent determination to uphold, reverse, or modify coverage denial." Review is based on medical condition and valid relevant scientific and clinical evidence and expert opinion, including provider recommendation and plan decision; no deference to provider or plan. Reviewer must consider but is not bound by plan definition of "medically necessary," 'experimental or investigational," or other substantially equivalent terms. No coverage for benefits specifically excluded or limited in "plain language" of plan terms can be required unless interpretation of medically necessary is involved.	Same as Kennedy/McCain/Edwards Similar to Kennedy/McCain/Edwards Similar to Kennedy/McCain/Edwards, but requires that care the plan has authorized be taken into account. No coverage for benefits specifically excluded or limited under the terms of the plan can be required – and clarifies that no coverage exists regardless of any determination of medical facts.
External Appeal Preauthorization timeline	Standard Review: In accordance with medical exigencies and ASAP within 14 days of receipt of information, but no longer than 21 days from receipt for external review. Expedited Review: In accordance with medical exigencies, but no later than 72 hours after request for external review. Concurrent Review: Within 24 hours of receipt of external review request.	Standard Review: Within 14 days of receipt of all information. Expedited Review: 72 hours after receipt of all information. Concurrent Review: Within 24 hours of receipt of all external review information. If plan reverses denial during the external review process, the external review terminates. Does not foreclose remedies for harm that has

Provisions	Kennedy-McCain-Edwards	Fletcher-Peterson-Johnson
		already occurred.
External Appeal Retrospective timeline	Within 30 days of receipt of information, but no later than 60 days after receipt of external review request.	Within 30 days after receipt of all information.
External Appeal Enforcement	External review determination is binding. If plan fails to comply, participant may obtain service "consistent with" determination from any provider and must be reimbursed by plan. Civil action authorized to recover amount of unpaid reimbursement. Additional civil penalties up to $1000/ day if plan refuses to authorize coverage ordered by review. Secretary may levy additional penalties up to $10,000 for failure to commence treatment in a timely manner. Cease & desist order permitted in case plan refuses to comply, with additional penalties up to $500,000 for "pattern of practice" of refusal.	Same. Secretary may access civil penalties: $2,000 a day for the 1st to 7th day, $5,000 for the 8th to 14th day, $10,000 for each day after 14 days to a maximum of $500,000. The Secretary may assess a civil penalty of the lesser of 25% of the aggregate value of benefits or $500,000 on an individual for failure to commence treatment approved by external reviewer.
External Review Entity qualifications	External reviewer must be certified by Secretary or qualified private entity as having sufficient expertise and staffing and meet other requirements established by Secretary including independence requirements. Certification period must not exceed 2 years. Must provide information relating to number, types, timeliness, and disposition of denials.	Same, except certification and/or recertification period cannot exceed 3 years.
External Reviewer Qualifications	Must meet established licensure, expertise, and independence requirements, and provide patient services at least one day per week. Must be same or similar specialty to provider involved in review and have knowledge appropriate to the age of the claimant. Compensation must not be predicated on decision and must be reasonable.	Similar, except reviewer must provide patient services of an average of at least two days per week.
Liability (Tort)	Authorizes two courses of legal action for claimants: Federal: Claimants may sue in federal court in cases involving non-medical decisions or the performance of <u>any duty</u> under the plan. State: Claimants may sue in state court in cases involving medically reviewable decisions. Must file suite in state the participant resides in.	Creates a two-tiered structure where claimants can sue in state courts if plan does not carry out decision of independent reviewer and in federal court in other circumstances, but not in both.

Provisions	Kennedy-McCain-Edwards	Fletcher-Peterson-Johnson
Liability (Civil penalties)	Creates federal cause of action with unlimited economic and non-economic damages, plus up to $5 million in punitive damages.	No limits on state damages available for state causes of action. Unlimited economic damages at the federal level.
Liability (Damage Caps)	State cases: No caps Federal cases: No cap on economic or non-economic damages. Court may impose up to $5 million penalty (punitive damages) for "bad faith" and "flagrant disregard" for rights of participant. Limits attorney's fees to 1/3 plus out of pocket expenses & are subject to review by court.	A cap of $500,000 is provided on non-economic damages. Punitive damages are prohibited.
Liability (Sponsoring Employer)	Allows protection of employer by appointing designated decision-maker. If employer is involved in any determination they would be liable.	Designed to protect employer by allowing the employer to use a designated decision-maker, which is usually the insurance issuer or administrator. Treating provider cannot be sued and is not eligible to be a designated decision-maker.
Liability (Exhaustion of Appeals Process)	Insured must exhaust appeals process prior to any court action unless process exceeds 31 days. Reviewer is still required to make their decision and decision is immiscible in court case. – Where participant alleges that irreparable harm might occur prior to external review or the participant first knows the injury after the deadline for requesting a review. Must bring action within 3 years of claimant's first knowledge of injury.	External review needs to be exhausted prior to going to court; however, patient may sue in court for injunctive relief at any time if participant proves that exhausting the appeals process would cause irreparable harm. External review must be exhausted in order to collect monetary damages. Must bring action within 2 years of participant's first knowledge of injury.
**********	Specific Provisions in Ganske-Dingell	
MSAs	Provides for some changes to current demonstration project	Eliminates any restrictions
AHPs	Allows for "Qualified Health Benefit Purchasing Coalitions.	Allows qualified associations to establish health plans and become the health insurer upon certification by the Secretary of Labor for insured or self-insured plans.